S. No. 300
DM—10-47
ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAR 22 1948
Registration District No. 317

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3064

State File No. 10992
Registrar's No. 671

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Ferguson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 804 N. Florissant Rd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Ferguson
(If outside city or town limits, write "RURAL")
(d) Street No. 804 N. Florissant Rd.
(If rural, give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country ---

3. (a) PRINT FULL NAME Katie Klinge
3. (b) If veteran, name war ---
3. (c) Social Security No. ---
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Charles H. Klinge
6. (c) Age of husband or wife if alive 84 years
7. Birth date of deceased June (Month) 4 (Day) 1866 (Year)

8. AGE: Years 81 Months 9 Days 7 If less than one day ____ hr. ____ min.

9. Birthplace St. Louis (City, town, or county) Missouri. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Victor Schaeffer
13. Birthplace Germany (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Marie Ritter
15. Birthplace Germany (City, town, or county) (State or foreign country)
16. (a) Informant Louise Klinge
(b) Address Ferguson 21, Missouri.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/48 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director White Funeral Home
(b) Address Ferguson, Mo.
19. (a) 3-12-48 (Date received local registrar) (b) Cecil A. Shaw MD (Registrar's signature) MSC

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11 year 1948. hour 10 minute A. M.
21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__; that I last saw her alive on March 11, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	2 days
Due to Arteriosclerotic cardiovascular renal disease	7 yrs.
Due to	
Other conditions Thrombo-angitis obliterans bilat. lower extremities (Include pregnancy within 3 months of death)	10 yrs.

Major findings:
Of operations
Of autopsy 131a

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature Joseph D. Judy (M. D. or other) MD
Address 9a S Florissant Ferguson Date signed 3/11/48

(Licensed Embalmer's Statement on Reverse Side)

APR 21 1948

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed L. M. Shlite

Licensed Embalmer No. 3973

P. O. Address Ferguson, Md

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.